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AN ATTEMPT TO PREVENT INFLUENZA AT HARVARD COLLEGE.

By George R. Minot, M.D., Boston,

Assistant Professor of Medicine, Harvard Medical School,

and

Robert F. Loeb, Boston.

Harvard College, at Cambridge, Massachusetts, opened on September 23, 1918, at which time the influenza epidemic in this vicinity was increasing. During the first week of college no essential measures were taken toward prevention of the spread of the disease in the college community, nor in other communities in that vicinity, though the disease continued to increase. However, on September 29, it was thought distinctly wise to try isolation and quarantine measures, and these were begun and carried out on the following day, with the help of picked medical students. The purpose of this communication is simply to give an outline of the methods employed and the results of careful supervision and quarantine of a group of about 1,450 men after a considerable number of influenza cases had occurred among them. Some of the men at first lived in college dormitories, and others at home or in boarding-houses; later, essentially all lived in college dormitories. It was possible to arrange for the methods employed because most of the men were organized into companies, as many were candidates for the Students' Army Training Corps, and were thus somewhat under military control, becoming actually under military control, as soon as they were inducted, which occurred between October 10 and 30. It was possible to conduct the isolation and inspection methods because of the coöperation between the military and college authorities.

This group of 1,450 men represents essentially all the men that were members of the Student Army Training Corps or simply of Harvard College on October 19. It does not take into account other members of the University or naval units, with whom these 1,450 men practically did not come in contact. During the first two weeks in college, some 200 or more other men were in Cambridge, temporarily associated with the Student Army Training Corps, and who, while in Cambridge, were under supervision similar to that given the group of 1,450. Many of these men were rapidly sent to officers' training camps, and it was not possible to obtain information about them. It is felt, however, that if these men had been included in the statistics given, it would have caused the per cent. figures given to be lower rather than higher, as no man was sent away who was ill or very recently had been ill.

Four days before the detailed supervision of the students' health was started, the physical examinations for candidates for the Student Army Training Corps were begun. This gave an opportunity to inspect some of the students each day prior to their daily careful supervision to be described later. Every man's temperature was taken before he entered the rooms where the physical examinations were conducted, and he was questioned in regard to his health. At least ten in each one hundred men were found to have some significant temperature, often associated with some slight symptoms,—usually a coryza,—and at least two in a hundred appeared to be early cases of influenza. At this time the men were advised what course to pursue, none being allowed to have their physical examination on that day. The same precautions were observed at the physical examinations throughout the days they were continued; but after the detailed medical supervision of the companies, rarely was there found any individual with a temperature. The number of infections found at the time that the first physical examinations were made was among the reasons that led to the isolation, quarantine and inspection of the students.

Before describing the more detailed arrangements for the management of these 1,450 men, it is necessary to describe their living conditions as arranged for and changed according to circumstances.

At the opening of college, only about 50% of the men were assigned to live in college dormitories. More were not assigned on account of a lack of supplies; these became available about September 30. It was at this time considered desirable to have no possible over-crowding, and to allow as little mingling of the men who had been living outside with those living inside the dormitories; so that at this time, no additional men were assigned quarters. The men living outside the dormitories, however, reported each day for duty with their companies, and remained with them during the day,—from after breakfast to before supper, under the same conditions as those living in dormitories,—who had essentially all their meals in the dormitories, except for a few who, during the first twelve days of college, had to eat in other places, and not under college supervision. The men who lived outside the dormitories in many instances lived at home, often within a five-mile radius of the college; some lived considerably farther away; others lived in boarding-houses in or near Cambridge. Thus many of this group of men had to go to and from college each day by public conveyances, and came in contact with individuals outside of the college.

On October 7, as the medical organization had matured, and as the cases of influenza had not materially increased, it was deemed wise to proceed in a special way with the assigning of men to quarters, because most of the cases of influenza had developed in the outside group of men. This also allowed the students to be under better control and to be inducted into the Student Army Training Corps. However, before assigning to quarters the men who had lived "at home," it was arranged that they should eat and sleep in a special quarantine dormitory for three full days. Thus 500 of these men, on October 7, were brought into a separate quarantine dormitory with its own dining-room, and 180 more men came to the same building October 10 for three days. Before they entered the building, the temperatures of all the men were taken, and they were inspected and questioned regarding their health. Suspects or those known to have been directly exposed to the disease were put in separate rooms in an isolation ward, which was in a separate building from the quarantine dormitory. This isolation ward will be described later. After sleeping and eating and having been carefully observed for three days apart from the other men, these men were re-inspected, and if apparently healthy, were assigned quarters in their company dormitory. Even with this further assignment of men to quarters, there was no over-crowding. It is to be understood that the men were not put in ordinary one-room barracks. Either a man lived in a single dormitory bedroom alone, or two men lived in a dormitory study of about 12x16 feet. Thus not more than three men slept in the same closed apartment.

Besides the provision for isolation in quarters with no over-crowding in them or in the dining-halls, the following plans were carried out as well as possible:

The students were at first requested, and on October 7 ordered, to remain inside of certain boundaries in Cambridge, outside of public places, shops, street cars, etc., unless they received a pass from the medical officer. The men who at first were living "at home" could not, of course, follow all of this schedule, and thus, as previously mentioned, in many instances they came in contact with the outside public. This seems of importance when one considers the per cent. figures of the cases of influenza occurring among them compared with those in quarters. It is also to be noted that circumstances prevented rigid quarantine before October 7, though quarantine measures were begun September 30, and were fairly well carried out during that week. Quarantine was continued until October 26.

All lectures or classes of over fifty men were stopped between September 30 and October 21. Military drill, however, was continued daily.

All officers of the college and Student Army Training Corps were ordered to report by name any individuals coughing or sneezing or appearing sick, and such cases were followed up.

The men who made the supervision of the students' health possible, and enabled them to be cared for and diagnosed early, were thirteen picked fourth-year medical students of the Harvard Medical School, one of whom acted as "captain" of the group. Nine men were made company "doctors" and one was assigned to each of the nine companies. One other student was put in charge of the isolation ward, and two others helped the medical adviser, Dr. Bailey, with the medical care of the sick cases in the college infirmary and in his office. These men continued their work from September 30 to October 19.

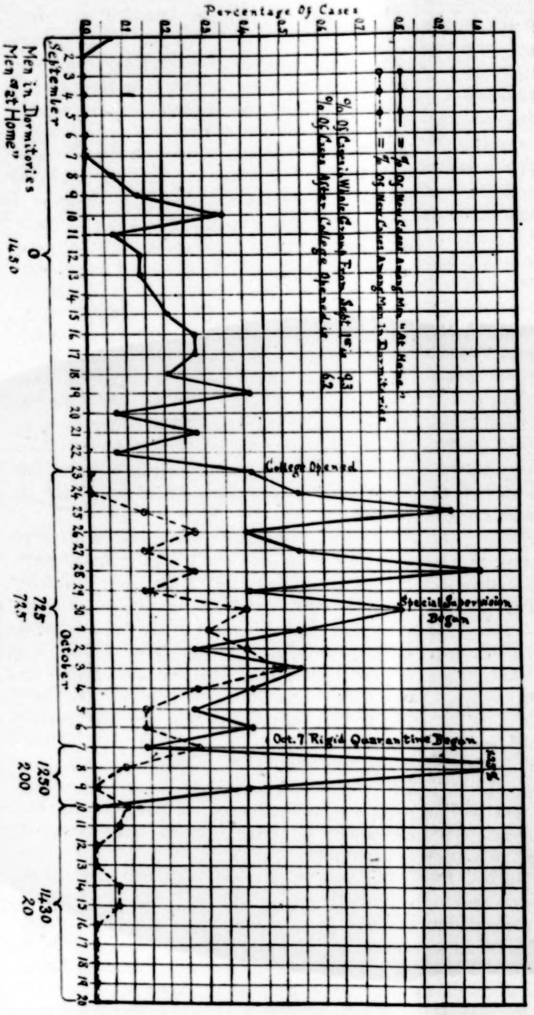
The company "doctors" held a sick call each morning, not only asking for men not feeling well, but inspecting men and using the thermometer freely. The men picked out of line were examined carefully later, and each "doctor" sent cases with any infection, no matter how slight, to the isolation ward. The men living at home were treated in the same way as those living in dormitories, except that at first a few with apparently simple colds were allowed to go and stay at home. None with significant temperature or who appeared to have more than a mild simple cold was ever allowed to go home. The company "doctor" was always available and saw that the men took care of their health; he inspected their quarters, furnished reports, etc.

An important function that was performed by the company "doctor" was to give two talks to his men about influenza, emphasizing the importance of reporting on the slightest indication of not feeling well, and the importance of taking proper care of their health, and asking their coöperation, etc.

Sick students were cared for in the following manner: Before October 1 cases of influenza were sent directly to the college infirmary. After October 1 the majority of the definite cases of the disease were sent directly to this hospital, but not all, because on that date an isolation ward was opened. This was a college dormitory building, with separate rooms, and a separate dining-room, and was in charge of one of the fourth-year medical students. Three types of cases, as follows, were taken here and kept separate from each other: (1) Men with apparently "simple colds" without temperature; (2) men with apparently "simple colds" with slight temperature, or those with slight temperature and without "colds"; (3) apparent cases of early influenza, not yet clearly diagnosed. The latter cases, as soon as definitely diagnosed, were sent as soon as possible, or within forty-eight hours, if not much better within that time, to the college infirmary.

The men with apparently simple colds were ambulatory and put out in the sun, but were kept separate from all others and carefully watched for at least forty-eight hours. If then it seemed desirable, they were sent back to duty. The second group were watched in a similar manner and were not ambulatory unless their temperatures were normal for over twenty-four hours. The men with the "simple colds" were quarantined because of the probable greater ease with which they might have acquired influenza, and because some such cases may have been influenza; to say nothing of the desirability of trying to prevent the spread of "simple colds."

The number of individuals that had apparently only simple colds and that could not in any way be considered to have the disease recognized as influenza, were as follows: Between 30 and 40 cases per day were reported during the first five days that the company "doctors" were at work. This, of course, includes a considerable number of men that developed the colds prior to September 30. During the next week, there occurred between 15 and 20 cases per day; and during the third week, about four a day. This number having only appar-



ent "common colds" gives an idea as to the frequency of such an infection at the time of the epidemic. One cannot help wondering whether some of these cases were not caused by the same etiological agent as causes the disease recognized as influenza. As this could not be determined they were grouped quite separately.

Masks were worn and the usual personal preventive measures were carried out by those in charge of cases, suspected cases, or examining for suspected cases.

The statistics obtained regarding the number of cases that occurred at any time among the 1,450 men are presented in the accompanying table and chart. Many very mild cases of but a few days' duration are included, besides all cases that could properly be called influenza, otherwise the statistics might be unduly favorable. Such mild cases probably are often not reported in cities, especially among the poor, because they do not call a doctor. In our series there were two deaths from pneumonia: one who developed the disease prior to October 1, and one after that date.

The total number of men who had influenza was 136, or 9.3% of the entire group. Forty-six of these cases occurred prior to the opening of college, as learned from the history given on questioning each man, so that 90 individuals, or 6.2% of the men, had the disease after coming to Cambridge. Of the 90 cases that had the disease after college opened, 60 cases occurred among those living outside the dormitories, and 30 developed among those living in dormitories; four of the latter occurred after practically all the men were living in dormitories.

The curves in the chart show the percentage of cases of influenza developing daily among

TABLE OF THE NUMBER OF CASES AMONG A TOTAL OF 1450 MEN.

	To Sept. 24	Sept. 24 to Oct. 2	Oct. 2 to Oct. 10	Oct. 10 to Oct. 21	Total
Before college opened	46				46
Cases among men "at home"		41	18	1	60
Cases among men in dormitories.		12	14	4	30
Total cases	46	53	32	5	136
Per cent. of the 1450 men living "at home" ...	100%	50%	23±%	2±%	
Per cent. of the 1450 men living in dormitories	0%	50%	77±%	98±%	

the total number of men living "at home" on any given day, as contrasted with the percentage of new cases occurring among the total number of the men living in dormitories on any given day.

From the table and chart, it may be seen that there was a considerably larger proportion of cases occurring among the men exposed to the public than among the men housed together and exposed somewhat at first to the public and later practically not at all.

Likewise it may be noted that after medical supervision of the men was well under way, and with the increased numbers taken into the dormitories, there was no increase of cases of influenza. It is to be recognized, however, that the disease was on the wane, which may have wholly accounted for the drop in the number of cases and for the absence of a greater number of cases among the men in the dormitories at this time. However, it seems probable that the detailed supervision and living arrangements outlined helped to prevent the spread of the disease, so that it did not occur in as great a percentage of men as it did in some army cantonments and naval stations.

We are inclined to believe that if strict quarantine and preventive measures had been employed for all the men when the first men began to live in dormitories, there probably would have been fewer cases among this group of men. We thus feel that rigid quarantine with adequate medical supervision is a most desirable method to at least attempt when trying to prevent influenza, or any disease apparently transmitted by contact.

Selected Papers.

TOOTH IMPACTED IN A SECONDARY BRONCHUS OF THE LEFT LUNG: REMOVAL BY LOWER BRONCHOSCOPY AFTER TWO UNSUCCESSFUL ATTEMPTS BY UPPER BRONCHOSCOPY.*†

By Sir StClair Thomson, M.D., F.R.C.P., F.R.C.S.
Professor of Laryngology in King's College Hospital, London.

The complete history of a single case, which is full of incidents, is sometimes of more value than a whole series of records of uneventful operations. The heading of this paper indicates its chief point of interest, but the tale I now unfold has many others which concern the laryngologist, the dental surgeon, and the family physician.

HISTORY OF ACCIDENT.

On November 20, 1917, a healthy girl, aged 10, of a nervous type, was placed under nitrous oxide anaesthesia for the purpose of removing the two first lower (temporary) molars. The left one was the first extracted; the dental surgeon drew it outside the mouth in his forceps and then shook it loose, with the intention of throwing it into the usual porringer beside the dental chair. But he noticed, instead, that the tooth fell on to the napkin, tucked under the child's chin, and was caught there in a fold. Without delay he proceeded to the extraction of the corresponding tooth on the right side; as he turned and threw this away the child, recovering from the anaesthetic, raised both hands (with the napkin above them) towards her mouth, making at the same time a deep inspiratory gasp. The dentist never suspected that at this moment the first tooth must have re-entered the patient's mouth, and no one was more astonished than he was, later on, when he heard the subsequent history.

When the child recovered from the gas, it was remarked that she was slightly wheezy. She returned by train to the country that afternoon, and in the evening the mother, noticing the wheezing, thought that her daughter had a slight cold. A few days later, the family attendant, Dr. Smallwood of Little Waltham, Chelmsford, was called in and found a catarrhal condition with very little air entering the left lung. Wheezing continued, and, in

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* Reprinted from *The Practitioner* August, 1918.

† Communication read before the Section of Odontology, Royal Society of Medicine, June 10, 1918.

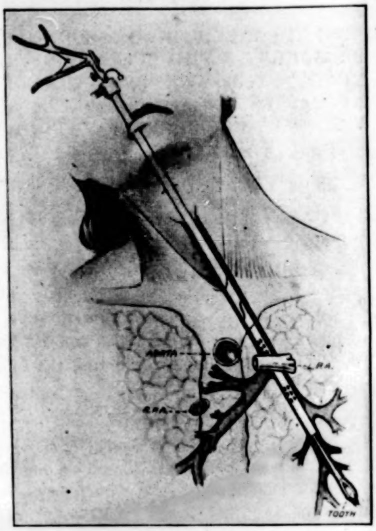

FIG. 1.—Upper or Per-oral Bronchoscopy. Semi-diagrammatic drawing, showing how the head and neck have to be flexed to the right so as to allow of the passage of the endoscopic tube into the left bronchus and its divisions. In the drawing, Moore's forceps are seen grasping the tooth in secondary bronchus, in a position similar to the case described in this paper.

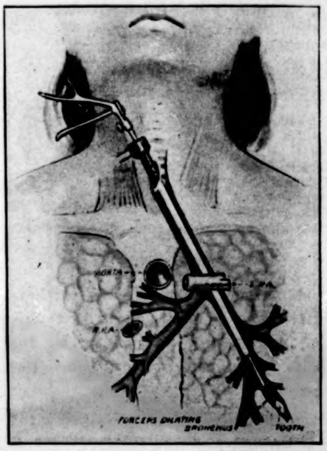

FIG. 3.—Lower or Tracheotomic Bronchoscopy. A semi-diagrammatic drawing showing the position of the endoscopic tube when introduced through the tracheotomy wound. The relation of the aortic and pulmonary arteries is also shown. In the drawing, Moore's forceps are seen dilating a secondary bronchus and seizing an impacted tooth as described in the present communication.

view of a definite family history, it was treated as possible asthma. Some relief was obtained, but no cure.

In view of the one-sided symptoms, Dr. Smallwood made further inquiry, and, on tracing the illness back to the period of the tooth-extraction, he shrewdly suspected that there might be a foreign body in the lung. A consultation with Dr. J. F. W. Still confirmed him in this hypothesis. There was then, a month after the visit to the dentist, a slight wheezing which was audible at a distance of a foot or two from the chest. Rhonchi were heard on both sides, but chiefly over the left lung, with absence of air entry towards the posterior border of the left axilla. There was a short cough.

An X-ray examination by Dr. Ironsides Bruce gave the following report:—

"Limited movements of the diaphragm on the left. The left lung showed increased translucency, the diaphragm remaining in a position of almost full inspiration. There is to be seen an opacity in the region of the root of the left lung; it possesses rather an indefinite outline, and is roughly rectangular in shape. The left lung shows increased translucency as compared with the right, and the left diaphragm lies at a much lower level in the thorax than the right."

Dr. Bruce's opinion on the finding was as follows:—

"On account of the history of a possible foreign body in the bronchus the opacity reported above, which lies in a position corresponding to the left bronchus, might well represent a tooth. But, on the other hand, it may represent a calcified root gland, though it should be noted, that its size, shape and position is not such as might be expected from such a gland."

This X-ray examination was confirmed by another by Mr. A. D. Reid.

FIRST EXAMINATION.

On December 28, 1917, I started to attempt removal by direct bronchoscopy through the mouth. Bromide was given for three days beforehand to diminish reflex. Chloroform was administered by Mr. Bellamy Gardner, and I was assisted by Dr. Irwin Moore.

I found the build of the patient showed narrow and long air passages, allowing only the use of a Brüning's 7 m.m. tube. Reflex cough was diminished, as I passed the tube down the trachea, by the application of cocaine to the larynx and the carina—which is the next most sensitive spot. I had to be moderate in the use of cocaine (a 2½ per cent. solution) owing to the age of the patient. After much searching the white glistening tooth was seen, tightly impacted in an externo-lateral secondary branch of the left bronchus, at a depth of 10½ inches from the teeth. (See Figure 1.) All my efforts to grasp it with various instruments failed. The narrowness of the bronchiole prevented a wide opening of any nippers, and the polished, smooth, ivory surface of the tooth gave no hold. I then made use of a long probe with a hook at the end, and insinuated it between the tooth and the bronchial wall, with the hope of either extracting the tooth or turning it round. The hook was passed beyond the tooth but all efforts to extract the tooth failed; what was worse, the hook appeared to catch in some other bifurcation close behind the tooth, and I found that I could extract neither the tooth nor the hook! I had forgotten Chevalier Jackson's warning that "hooks with a curve greater than a right angle are very apt to become engaged in small orifices and to be very difficult in removal" (p. 272, *op. cit.*). After some anxious five or ten minutes I succeeded in disengaging the hook with only slight traumatism.

The tooth remained in position.

The patient had now been under chloroform for 1 hour 45 minutes, so I decided to abandon the attempt that day.

DIFFICULTIES.

In his classical work on *Peroral Endoscopy and Laryngeal Surgery* (St. Louis, Mo., 1915, p. 289) Professor Chevalier Jackson, of Philadelphia, has the following paragraph: "One of the most difficult mechanical problems is where a foreign body completely occludes a bronchus into which it is tightly drawn by the absorption of air below, and that in addition has a conoidal form towards the operator. The problem is difficult, especially if the intruder is hard and smooth, because the forceps cannot get a large surface of contract and hence slip." I was evidently, in American parlance, "up against" an even more difficult proposition, for not only had I to do with a smooth, ivory, conoidal surface, but with a foreign body which was tightly impacted, not in a main bronchus but in a secondary bronchus. To this point it must have been straightway drawn with that first deep inspiration as the child recovered from the anaesthetic, for it is noteworthy that, from that moment, there had been no attacks of spasm or violent coughing such as there would have been if the tooth had at any time been loose in the trachea or large bronchi. Moreover, the tooth had been fixed in this bronchiole for five weeks—time enough to allow of all the air beyond being absorbed and the tooth becoming more tightly impacted.

For those who do not know his work, I might say that, in matters of endoscopy, Chevalier Jackson is *il maestro di loro che sanno,* and that we are all willing and eager to learn from his great skill and large experience. I have little doubt that he has removed more foreign bodies from the food and air passages than any other single laryngologist in the world. He has been able to gain this position by specializing in this line, and by having all North America as a field of practice. Anyhow, after the first failure I turned to his writings and there read this dictum (p. 258): "Any intruder that has gone down through the glottis can be brought up the same way, if turned to the position of least resistance." I was not sure of being able to turn the tooth, but I determined to make a second attempt at peroral extraction.

From the first examination my little patient had no shock or upset. She slept well and swallowed easily; the temperature did not rise above 99°; and within a few days she was out walking. An x-ray plate by Dr. Ironside Bruce showed the tooth still present in a left secondary bronchus, and even deeper in the lung.

SECOND EXAMINATION.

Eight days later, on January 5, 1918, chloroform was again given. There was much more reflex cough and secretion of mucus this time; the tooth was discovered more deeply; less of it was visible, owing to swelling of the mucosa. I found it very difficult to keep the tooth well in view in the centre of the field of vision owing to the strong traction towards the patient's right side which I had to maintain on the handle of the instrument, in order to direct the beak of it well towards the left axilla. I was about to introduce Dr. Irwin Moore's well-known non-slip forceps when—doubtless owing to the aforesaid traction dragging on the root of the lung or on the heart—the patient suddenly collapsed, and had to be restored by artificial respiration. She had been under the anaesthetic 40 minutes. There was no shock or feverish reaction from this examination, but after these two ordeals I thought it best to let the child go to the country—which she did five days later.

ALTERNATIVES.

What was to be done? Were we to "wait and see," a policy which has gone out of favor in endoscopy as it has in politics? Foreign bodies have been coughed up many a time in days gone by, sometimes after a prolonged stay in the chest. But, unfortunately, statistics do not help us in this, for we never know in what part of the air-tract the intruder had been sojourning, nor how firmly it had been fixed. A large, light, foreign body, mobile in the trachea or a main bronchus, may easily be coughed up; but there is little chance of such a happy expulsion with a small, solid, smooth substance tightly impacted in a secondary bronchus and with all the air on the far side of it absorbed. On the contrary, each deep breath—preliminary to an explosive cough—would tend only to wedge it more deeply.

There was the alternative of the tooth becoming loosened by suppuration taking place around it—almost certain to happen in time—and its being expelled through the mouth with the discharge of the abscess. But, unfortunately, even with such a development there was no certainty that the pus would remain localized and burst towards the main bronchus, nor that it would bring the tooth with it. The pus might just as readily diffuse in the lung and cause sepsis.

I considered the possibility of thoracotomy. The results of this operation are not brilliant. Considerable progress has, I believe, been made during the great European War in removing through the ribs fragments of shells and other missiles which have entered the lungs. But there is a great difference between following the track of a foreign body which has penetrated into the lungs through the chest wall, and hunting around from the outside of the thorax for a foreign body which has entered from the glottis and lies at the root of the lung, close behind the pericardium.

While weighing these considerations, I made some investigations with Dr. Moore on the cadaver, and he further perfected some forceps for securing a good grip.

LUNG ABSCESS DEVELOPS.

Action, however, had soon to be decided on, owing to developments in the case. The patient, as I have narrated, returned to the country after her second anaesthesia on the 10th January last. Dr. Smallwood reported that "there is no wheezing and only occasional slight shortness of breath." There was slight deficiency of air entry in the left axilla, rather toward the posterior fold. The heart's apex was about ¾-in. outside the nipple, probably due to collapse of a portion of the lung and the heart swinging over to take its place. She continued to eat and sleep well, in spite of the tooth in the lung, and the temperature was normal. But it soon began to rise (see Chart, Fig. 2), until it was oscillating from 97° every morning to 101°, 102° and 103° in the evening. An X-ray by Dr. Ironside Bruce showed the tooth as before, or even deeper, with commencing opacity in the left lung. Abscess formation had evidently taken place and action could not be long delayed.

I was glad to share the responsibility of my third campaign by having a consultation with Dr. Dundas Grant and Mr. E. D. D. Davis. After hearing the history and difficulties of the case, these colleagues were unanimous in strongly recommending that there should be no further attempt at removal by upper bronchoscopy (*i.e.*, through the mouth); that there was no objection to tracheotomy except the slight scar, which I had wished to avoid in a young lady; that tracheotomy would enormously facilitate extraction, and that, in the event of failure to extract the tooth, the patient would be much safer with a tracheotomy tube in her neck if we should be compelled to await a later chance of spontaneous expulsion.

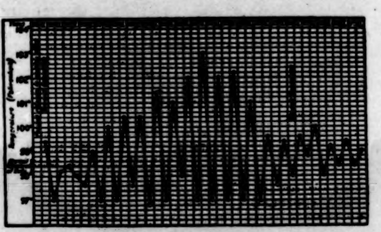

Fig. 2.—Chart of temperature indicating formation of abscess in lung, beyond the impacted tooth.

I readily agreed to this after the experiences I have related, and also because I had already fulfilled one of Chevalier Jackson's rules, which is as follows:—"If the first bronchoscopy is not successful after 15 or 20 minutes in a child, it is better to desist, wait a few days, and repeat the oral bronchoscopy at least twice before resorting to the tracheotomic route" (p. 252).

THIRD EXAMINATION AND SUCCESSFUL REMOVAL.

Next morning, January 26, 1918, chloroform was administered by Mr. Bellamy Gardner. I had given bromide for three days beforehand. Again I was assisted by Dr. Irwin Moore, and also had the valuable help of Dr. Dundas Grant and Mr. E. D. D. Davis. The trachea was quickly exposed without having to tie a single vessel. I injected a 2½ per cent. solution of cocaine, with a little adrenaline, into the lumen of the trachea by stabbing between the rings with a hypodermic needle. This abolished any cough on opening the trachea. Through the tracheotomy wound I was able to pass a 10 m.m. Brüning's tube, instead of the narrow 7 m.m., which was all I had been able to introduce through the glottis. I came readily down on the tooth at a distance of less than 5 1-2 ins., instead of the 10 1-2 to 11 1-2 ins. interval by which I was separated from it in the two previous examinations. Any approach of the instrument to the tooth caused reflex barking cough. Some little time was spent, therefore, in cocainizing the region. As this was being done some milky fluid kept oozing upward alongside the tooth. Finally, when a swab produced no reflex on touching the tooth, I took a pair of Killian's "bean forceps" down to the tooth and then dilated them so as to free the tooth and get a good grasp (see Fig. 3). This must have released the pus pent up behind the tooth, for there was a gush of yellow fluid, and, for the moment, I thought I should be balked in removal. But, knowing I was in good position, I carefully closed and withdrew the forceps and found the tooth firmly grasped in the middle of them. One or two teaspoonfulls of yellow pus welled into the left bronchus and were cautiously sponged out, while the head and thorax were lowered in the Trendelenburg position. I left the bronchiole clear, with only a minute granulation in it.

From the beginning of the tracheotomy to the removal of the tooth, the time occupied was exactly 29 minutes. There was no shock or collapse.

Complete Recovery.—The after-history was uneventful. In an effort to avoid all scarring I closed the entire wound in the neck with buried catgut and superficial silkworm and horsehair sutures, but the two or three middle sutures had to be cut away, as there was some cough leading to subcutaneous emphysema, which extended right up to the eyes. One month afterwards the patient went to the seaside, and Dr. Smallwood wrote to me as follows:—"She seems very fit, and the chest is clear as far as I could make out except a little deficiency of air entry in the left lower axilla." The scar in the neck is insignificant.

FOREIGN BODIES LESS FREQUENT IN LEFT LUNG

I might here remind my readers that it is decidedly rarer to meet with foreign bodies in the left lung than in the right. Statistics agree in this, although the figures show the proportion entering the right bronchus vary from 75.4 per cent. (Gottstein) to 70.2 per cent. (von Eicken) and 62.5 per cent. (Morell Mackenzie). Some of the reasons for this are demonstrated by a reference to Fig. 4 taken from my text-book.[1] It will be seen that the diameter of the right bronchus is decidedly larger than the left; indeed, it is very slightly narrower than the trachea itself, with which it is also in a more direct line, owing to the less angle of deviation. There is also a larger volume of air being drawn along the right

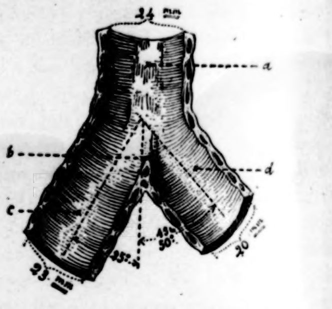

FIG. 4.—Semi-diagrammatic drawing of a vertical, transverse section of the bifurcation of the trachea, viewed from the front.

bronchus. This picture also explains why, while it is rarer for a foreign body to enter the left bronchus it is also—on account of the greater obliquity—much more difficult to get the intruder out!

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I had not intended attempting a study of the records of the falls of teeth into the lower air passages, but, by pure accident, I came across a communication which is very interesting when compared with my own, whether from the points of diagnosis, method of treatment, or after-result. In 1908, Mr. Rutherford Morison read "Notes of a Case in which a Portion of a Lung was Excised" before the Medical Society.[2] This turned out to be the case of a woman of 36 to whom chloroform was administered while 6 to 8 stumps were extracted. On recovery she found one tooth lying loose. between the cheek and gum, and spat it out; and at the same time, felt difficulty of breathing and a tightness in her chest, and expressed her own conviction that a "stump had gone down her throat." Three weeks later a long illness started with cough, blood spitting, profuse and foetid expectoration, and loss of weight and strength. This went on for two years before the diagnosis was made of bronchiectasis limited to the lower part of the left lung caused by "a tooth impacted in a bronchus," although "Roentgen ray examination showed no abnormal shadow." Operation from the outside was attempted by resecting 6 ins. of the eighth rib. A large portion of the lower lobe of the lung was removed (see Fig. 5), but the patient died 28 days later from pericarditis.

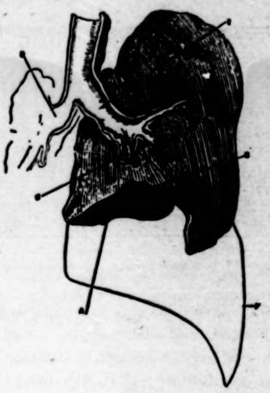

FIG. 5.—A, Cut and healed surface of lung; B, stump of tooth in bronchus; C, probe from cut surface through open bronchus to tooth; D, right bronchus; E, left bronchus; F, outline of lower part of lung excised.

The post-mortem showed that the tooth-stump was impacted in a secondary bronchus, and that it had been missed at the operation only by three-quarters of an inch.

At the ensuing debate J. Kingston Fowler referred to a case of a tooth in exactly the same position; a cavity formed in the lung; operation from the outside failed and the patient ultimately died from pulmonary tuberculosis. A. Barker narrated a case of a tooth in a right bronchus leading to gangrene and an empyema. It was decided to attempt removal through the chest wall, but "the first few whiffs of chloroform proved fatal."

The fact that three separate personal cases of a tooth in the lung could be recorded at a meeting of a general medical society would appear to indicate that the accident may not be so rare as one might think. That X-ray examination should have failed to detect the tooth shows how far radiology has progressed in these eight years, and that endoscopy should not have been employed in Mr. Morison's case demonstrates how slowly the knowledge spreads in the profession of the recent rapid progress of laryngology. The case conveys one other lesson for all of us, and that is, not to disregard a patient's own feelings when he says that he feels something has stuck in the throat or chest.

A recent discussion in America shows that bronchoscopic cases of dental origin are by no means uncommon. Indeed, one speaker suggested the necessity of a detailed method of observation and counting in the extraction of teeth, similar to that provided by the abdominal surgeon in cases of sponges and instruments! This would not entirely cover the ground, for in the above debate the following articles of a dentist's armamentation were mentioned as having been retrieved from the lungs:—teeth, gold crowns, bridges, dental burrs, pieces of rubber, and fragments of plaster of Paris models!

UPPER AND LOWER BRONCHOSCOPY COMPARED.

The comparison of upper and lower bronchoscopy (or the per-oral and tracheotomic routes) calls for some consideration (Figs. 1 and 3). In his own last 182 cases, Chevalier Jackson records that the foreign body was found and removed in 177 cases, and that in each instance he did without a tracheotomy (*op. cit.*, p. 246). He is an ardent supporter of this route, as I have already quoted. The above figures show his success, and the safety is demonstrated by his death-rate of 1.7 per cent. He attributes his success largely to the lateral or forward flexions which can be given to the head by a specially trained assistant, so as to extend the angle formed by the trachea and bronchus (the "Boyce position"). But his precepts—or his successes—are not invariably followed. In 1913, he collected a record of 156 foreign bodies removed by various operators in the United States; of these, 22 were extracted through a tracheotomy opening. I have no doubt that Jackson's endorsement of the upper route is well founded, in his case, by this exceptional experience, his completely organized clinic, his permanent and highly trained assistants, and the evolution of "team work," which is well established in America but only beginning to be talked about here. In addition, he has the advantage of being accustomed to work with narrower instruments and without a general anaesthetic. I also agree, as I have already said, that at least two attempts should first be made in most cases to effect extraction by the mouth; and I note that Jackson says that "he regards tracheotomy as perfectly justifiable in any case in which the surgeon in charge deems tracheotomy for any reason whatsoever indicated for the best interests of the patient" (p. 258).

After all, it is the interest of the patient which must settle any question of nicety of an operation. Endoscopy of the air and food passages must always remain in the hands of the expert laryngologist. If he is well experienced and in regular practice, he will first approach such cases as mine through the mouth, and in most cases he will succeed. This is the first, in my practice, in which I have failed since I went to learn the technique at Freiburg in 1902. But in a certain number of cases, particularly the rarer and more difficult ones which occur in the left lung, the lower route, through a tracheal opening, is in the interest of the patient. It will also be the route taken more readily by those who are less experienced, for it enables the surgeon more promptly to live up to the old adage that he should cure his patient "*tuto, cito et jucunde.*" In the present case there was hardly any room for comparison between the difficulties and anxieties of the two per-oral interventions and the facility, simplicity, safety and promptness which were obtained by operating through a tracheotomy orifice (Plate III., Fig. 3). To be brief, the advantages of the better route can be summarized as follows: (1) Less anxiety with the anaesthetic, for we all know the administration through a tracheotomy opening avoids all pharyngeal and laryngeal reflex and is therefore much smoother and safer; (2) Ability to succeed without several trained assistants, because there is no longer the necessity to mobilize the head; (3) The use of a wider and shorter tube, thus obtaining (4) better illumination, (5) a larger field of vision, and (6) increased facility of manipulation; (7) Less leverage and traction on the important structures at the root of the lung; (8) Shorter sitting; (9) Greater certainty in result; (10) In the event of failure, or of the foreign body shifting its position during the séance, the tracheotomy is a decided security. I must add that in my case the abscess formation had loosened the impaction of the tooth and so mitigated one of my difficulties before the third intervention.

In comparison with the advantages, what are the drawbacks of a tracheotomy? Except for the trifling scar—of no importance to any individual compared with a risk of life, and valued only by young ladies who have to go *décolletées* to Court, and are not yet possessed of a diamond dog-collar!—I know of none. The death-rate from a preventive tracheotomy should be nil; it is the circumstances of a tracheotomy done for relief, or the results of a delayed tracheotomy, which cause disaster. In the present case, it was the adoption of the tracheotomy route which saved the child's life. I think lower bronchoscopy will therefore be the necessary method in certain circumstances, or when foreign bodies are tightly impacted, or when they have receded to the deepest corners of the airway, and particularly in the greater difficulties presented by their entry into the left chest.

In these views I am glad to find myself in accord with Dr. R. Paterson (Cardiff), who has twice adopted lower bronchoscopy in young children after failure by the per-oral route.[4]

PRECAUTIONARY TREATMENT IN SIMILAR CASES.

I might well be asked what line of action a dental surgeon should follow if he thinks, or even suspects, that a tooth or other foreign body had entered the air passages while his patient is in the chair. Well, the first and most important indication is given us in the good old medical principle "*primum non nocere.*" We must first bear in mind the things the dentist should not do, and Chevalier Jackson has tabulated the following seven "donts."

1. Do not reach for the foreign body with the finger, lest the foreign body be thereby pushed into the larynx, or the larynx be thus traumatized.
2. Do not make any attempt at removal with the patient in any other position than recumbent with the head and shoulders lower than the body.
3. Do not hold up the patient by the heels, lest the foreign body be dislodged and asphyxiate the patient by becoming jammed in the glottis.
4. Do not fail to have a radiograph made, if possible, whether the foreign body in question is of the kind dense to the ray or not.
5. Do not fail endoscopically to search for a foreign body in all cases of doubt.
6. Do not pass an oesophageal bougie, probang, or other instrument blindly.
7. Do not tell the patient he has no foreign body until after a radiography, physical examination, indirect examination, and endoscopy have all proven negative" (235 *op. cit.*).

It will be gathered that several of the above precautionary measures are advised so as to prevent gravitation attracting the foreign body, particularly if of small size, into a deeper secondary bronchus. It is better, if possible, for the patient to rest until he can be treated lying flat and face downwards. In this position there is less likelihood of the foreign body falling into the middle or upper lobe secondary bronchi regions, where it is particularly inaccessible, and it is into these undesirable tubes that it might gravitate if the patient lay on his back or on one side. The patient should not be encouraged to cough or hawk up. The chances of success are small if the foreign body has passed the glottis, and the efforts may only drive the point of a sharp substance, like a pin or tack, deeply into the mucosa. In the case of a loose or larger body, the cough may drive it up into the glottis and so threaten asphyxia. If one felt certain that the tooth or other foreign body was in the oesophagus, these rules would not apply, but, short of that, it is wiser to follow them as nearly as possible until the case can be placed in the hands of a skilled laryngologist.

A MEDICO-LEGAL ISSUE.

That similar cases may be fraught with unpleasant legal consequences is shown by a paragraph in the *British Medical Journal* of December 7, 1912. It is therein recorded that a Glasgow dentist was sued for £1,500 damages. The pursuer alleged that in February, 1908, the defender allowed a portion of a tooth to fall down the pursuer's throat into his right lung; three years afterwards, during a paroxysm of coughing, he coughed up the tooth. Fault was denied by the defender. At the trial in March last a jury, under Lord Ormidale, returned a verdict for the pursuer, and assessed the damages at £750. The defender appealed for a new trial, on the grounds that the verdict was contrary to evidence, and that the damages were excessive. The report in the *British Medical Journal* concludes as follows:—"The Division of the Court of Session (Lord Johnston dissenting) refused the application of a new trial. Lord Johnston was satisfied that the defender had suffered an in justice, and that the verdict was not only a bad one but that it was given in circumstances which called for a new trial, and he thought he was bound in fairness to the defender to say so."

I entirely agree with Lord Johnston, and I cannot imagine how any jury could give a verdict against a dentist after a similar accident, unless it were proved that the dentist neglected to use reasonable care. The accident might be caused by sudden movements of the patient, as in my case. Even when the patient is under a general anaesthetic, his unconscious movements, and the consequent inspiration of the tooth might be fairly attributed, in some cases, to his previous alcoholic excesses, and not to the dentist's clumsiness! Or, again, might not inefficient administration of the nitrous oxide gas be the chief cause, and the anaesthetist be held responsible?

The public are only too ready to run all sorts of risks from quacks and charlatans, and to be silent when their silliness lands them in disasters; but they are equally hasty to blame the legally qualified dental surgeon or medical man if everything is not to their perfect satisfaction. Fortunately, the law of England is very fair and just, and we have rarely to complain of actions for malpraxis.

RESULTS OF BRONCHOSCOPY.

Let me just conclude by recalling what endoscopy has done for the benefit of humanity. In former times a certain number of foreign bodies, loose in the larynx or trachea, were coughed up sooner or later. Still, statistics in pre-bronchoscopic days show a death-rate of 52 per cent. The early years of bronchoscophy, *i.e.*, up to 1908, reduced the mortality to 13.1 per cent. (von Eicken). In 1909 and 1910 this was further reduced to 9.6 per cent. (Kahler). By 1913 the death-rate of various surgeons in the United States had fallen to 5.3 per cent., and Chevalier Jackson's own practice in his last 182 consecutive cases of bronchoscopy for foreign bodies give a total of three deaths (1.7 per cent.) (p. 246, *op. cit.*).

Deaths that do occur are less attributable to bronchoscopy than to the results of the sojourn of the foreign body or to blind efforts at removal.

NEED OF EXPERT HANDLING.

But these favorable results can be secured only in experienced hands. Fletcher Ingals says he has seen numerous cases of fatal results from bronchoscopy, and he believes that "the fatalities with inexperienced people would run between 10 and 20 per cent. if all cases could be collected." The same writer appreciates the strain put on us by such cases. He writes: "The heart-breaking delays, the extreme anxiety for the patient, and the knowledge that prolonged operations of the kind are dangerous, while failure may spell death for the patient, place the operator under such circumstances under an indescribable stress." No wonder Chevalier Jackson says: "There is absolutely nothing like it in the whole realm of surgery."

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Society Report.

ABSTRACT OF THE PROCEEDINGS OF THE FORTIETH ANNUAL CONGRESS OF THE AMERICAN LARYNGOLOGICAL ASSOCIATION, HELD AT ATLANTIC CITY, NEW JERSEY, MAY 27-29, 1918.

(Concluded from page 649.)

THE VALUE OF THE DICHLORAMIN-T CHLORCOSANE SOLUTION (DAKIN-DUNHAM) IN THE TREATMENT OF INFECTIONS OF THE UPPER AIR PASSAGES.

D. BRYSON DELAVAN, M.D., NEW YORK.

Dichloramin-T, the basis of the Dakin-Carrel fluid, so extensively used as an antiseptic in a wide variety of infectious conditions, as an intense germicidal action corresponding to its high content of chlorin. It is difficult to find for it perfectly satisfactory solvents which will yield stable solutions. Drs. Dakin and Dunham state that the best medium thus far found is an oil obtained by the chlorination of paraffin wax, to which has been given the name "chlorcosane." Other solvents experimented with are a mixture of eucalyptol and a paraffin oil, and a heavy oil obtained by the chlorination of eucalyptol. Eucalyptol has been found to be irritating. Chlorcosane is not irritating and has seemed decidedly preferable. Explaining the action of dichloramin-T in oil, Dr. Dakin says that antiseptics incorporated with or dissolved in oily substances usually possess little if any antiseptic activity, because intimate contact with the infected matter is hindered by the oil. When, however, the dichloramin-T solution in chlorcosane is brought in contact with aqueous media the partition coefficient between the oil and the water is such that a certain amount of the dichloramin-T passes into the water and there exerts its germicidal action. The amount of the dichloramin-T thus passing from the oil is increased by the presence in the aqueous medium by substances capable of taking up chlorin, so that the oil solution seems as a store for the antiseptic which is drawn upon to maintain the germicidal activity of the aqueous medium with which it is in contact. The dichloramin-T oil solution may be sprayed upon wound surfaces or poured into accessible parts of deep wounds. It yields moderate amounts of the antiseptic to watery media, such as secretions from wounds or mucous membranes. It is suitable for sores requiring prolonged antiseptic treatment and for first dressings of wounds which do not require irrigation. The application of the oil is extremely simple, and generally it need not be renewed more than once in twenty-four hours.

Admitting the germicidal power of dichloramin-T, it is desirable to study its value in the disinfection of septic conditions of the upper air passages, regions especially liable to infection, prone to harbor germs of dangerous character, abounding in recesses difficult of access by the ordinary means of application, and often becoming foci of infection threatening extreme danger. This is especially true of the upper nasal region, the vault of the pharynx and the tonsils. The dichloramin-T may be used to advantage in these regions under three different conditions:

1. To prevent the extension of newly acquired infection.
2. To overcome the acute results of infections, and
3. To abolish the bacilli persisting in carriers.

The success of the method must depend upon the thoroughness of the application of the disinfectant. Brushing the surface of the tonsil or spraying the lower section of the nasal cavity cannot possibly be effective. A spray atomizer must be used which will carry the spray in all directions,—upward, downward, and sidewise.

The crypts of the tonsil must be disinfected to their lowest depths, and the superior half of the nasal cavities must be thoroughly reached. To effect this the following principle must be recognized and carried out: The parts must first be cleansed, and then exposed to the fullest extent by the application of adrenalin or some similar astringent, and finally the dichloramin-T oil sprayed into them until every crypt and recess has been completely reached. This thoroughness is absolutely necessary in order to secure the removal of the most deeply seated germs.

Used in the strength of 2% or less, the solution with chlorcosane is not irritating, although stronger solutions may be. Suitable atomizers are necessary. The success of this method has thus far been gratifying.

Where this method fails, in the presence of hypertrophied tonsils or adenoids, the removal of the latter may be necessary to effect a final cure.

The desire of the author is to furnish a method so simple in itself as to be readily carried out by the average practitioner with the aid of apparatus inexpensive, durable, clean, compact of form, light of weight and therefore available for use under all circumstances of medical practice, whether civil or military.

The essentials to success are:

1. Recognition of the principle of the necessity for the complete exposure of the centers of infection.
2. The use of a proper spray atomizer.
3. The devotion of sufficient time and care to the effective carrying out of the treatment.

DISCUSSION.

Dr. Joseph H. Bryan, Washington: I believe that this method of treatment is going to be of valuable assistance to us in correcting these conditions. I cannot understand how the spray can get into the deeper portions of the tonsils, however. I have been using a small dental syringe, by which the solution can be carried into the depths of the tonsil better than by the spray.

Dr. Robert C. Myers, New York City: I have been experimenting for several months with these preparations of Dr. Dakin's fluid, although nothing definite has resulted. A great many of the cases seemed to have been relieved, and it would seem theoretically that it is the best thing that has been proposed. I have used it in solutions and mixtures, and the difficulties in reaching the depths of the crypts need, I might say, some consideration. Many of us have been trying to swab out the depths of the crypts and have always produced a certain amount of hemorrhage on account of the delicate structure of the parts, leaving a blood clot to be a culture medium for the germs. I have used also the watery solutions in tracheobronchial conditions, and so far the results have been very satisfactory. I do not believe that I have a case which apparently was pneumonic that has not stopped. When the oily solutions were used a great deal of precaution was observed in dropping them into the trachea, and spraying came in readily with the watery solutions. I preferred the latter, on account of my faith that too much paraffin oil going into the lower bronchi might not be brought back again. Not being observable, it was a question what would become of it.

Dr. Cornelius G. Coakley, New York City. Chronic meningococcus carriers in the Rockefeller Institute were examined one afternoon by myself. The conditions found were almost identical in all—a most intense hyperemia, redness, with moderate swelling of the nasal, nasopharyngeal and pharyngeal mucous membrane. I have never seen such red throats, and none had had during the past four days any other local treatment so that I could not find any conditions there that were the result of local treatment. Of the twenty-seven, twenty-four had perfectly enormous masses of adenoids in the nasopharynx. I have rarely seen such masses of adenoid tissue in adults. They were great big husky men from the Middle and Far West, fine specimens of manhood, yet with masses of adenoid tissue bigger than my thumb as proved by removal by Dr. Babcock later. In twenty-four that was the size. In two there were smaller amounts, and in one, none. One patient had a sinus involvement. I feel that neither the dichloramin-T nor any other local disinfectant can have any great bactericidal or germicidal value when we find such masses in the nasopharynx as were present in these twenty-four cases. I believe that this was the cause of continued finding of the meningococcus. The results of operation will be noted later on. Last fall I had a smaller number, about ten, who were sent from one of the cantonments of the South to the Rockefeller Institute for study, and we found in all large tonsils and adenoids. When these were corrected, they promptly cleared up in two weeks, and they were long-standing cases. So I think from what little I know at present, that if you have a smooth surface which can be readily acted on by the antiseptic, dichloramin-T, you will get good results, but if you have a rough surface its efficacy is much less.

Dr. Harmon Smith, New York City: I have had more or less success in employing this solution, beginning with dichloramin-T chlorcosane, in February. I believe that the most important point is to have the surface clean and the sinus clear of any invading pus or mucopus found there. In addition, we should not only bring the solution in contact with, but force it into these rugae. I have shrunken the tissues down first, and then irrigated with an aqueous solution of some alkalin or normal saline, and afterwards instituted suction until there was no evidence of pus in the solution coming away. Then I have employed a syringe, which I have endeavored to impress on some as being efficient. It is loaded as an ordinary syringe, with a 2% solution of dichloramin-T. Then, by turning the stop cock, I bring about a vacuum in the sinus, after which I turn the cock and force the solution in, using the vacuum together with the force of the syringe to force in the solution. I have had more success with the dichloramin in oil than with the aqueous solution. This method has been more or less condemned by some, and they may have their reasons for it, but in my hands it has met with considerable success. In addition to the treatment of the patient it is necessary for the patient to do something in the interim between the calls at the office. I give the patients a weak solution of adrenalin, with which they spray their noses first, and later with a normal salt solution they irrigate the nose until the first outpouring of mucopus is over. I also give them a bulb that will give, on the Sorenson machine, a ten degree registration on the dial. Employing this at home, they can keep the sinus more or les free from mucopus, and one then has less to get out in the office before employing the injection with the syringe.

Dr. Emil Mayer, New York City: My experience with this solution in oil many months ago was that it produced so much irritation in the cases of otitis that I was rather chary about its use in cases in which there was much sensitiveness of the mucosa, so that I have recently been using the watery solution in cases of bronchiectasis and bronchial abscess, washing them out, and at the same time using the suction apparatus, and then throwing in the watery solution. I took a number of the cases that were under observation and, for control, used the old solution of iodin and carbolic acid, and in the others I used the chlorcosane. The site of application is in the bronchus. Drawing out the very excessive secretion by means of the suction apparatus, which was attached to a double tube, the irrigation could be continued while the suction was being used. Our experience has been of such short duration that I am unable to do more than report a decided amelioration of the worst symptom of the patients, the odor. Whether we can use a solution in oil in the bronchus remains to be seen. I will experiment later on, and hope to get better results with the oily solution.

Dr. Robert Clyde Lynch, New Orleans: I have used dichloramin solutions, both aqueous and oily—the oily in 2% as described. In the sinus cases, especially the antrums, a few of the sphenoid involvements and four broncho-sinus cases, we irrigated the sinuses first with normal salt solution, following this by irrigation of the sinus with the aqueous Carrel-Dakin solution. Then we instilled into the sinuses—and antrum, frontal and sphenoid—thirty minims to a dram of the oily solution. This was naturally followed at first by an apparent increase in the inflammatory state of discomfort, which lasted on an average for about six hours. On the return of the patient the following day, we washed from the sinus apparently more secretion, but it was usually changed in character. That is, instead of the secretion showing a tinge of blood or being bloody, there was on the patient's return what appeared to me to be an excess or an irritation of what would be a normal mucous membrane. In other words, the washing from the sinus lost the peculiar mucopurulent sanguineous type, and was changed to a thinner watery discharge having a considerable amount of apparently clear mucus. In the cultures taken from these washings there was a notable decrease in the diplococci, but the usual history of the time of clearing up of the sinus did not seem to be shortened to any great degree. In other words, running parallel cases, we found, as the winter wore on, that we were able to accomplish almost the same results by irrigating the sinuses with a normal salt solution or with a solution of permanganate of zinc. We were able to accomplish convalescence in about the same time as with the dichloramin solution. We then tried simply washing the sinus with a plain tap water, following that with the instillation into the sinus, through the cannula, of from one to two drams of 2% dichloramin oil and allowing that to remain in for as long as it would stay, requesting the patients to sit upright and refrain from blowing their nose. They apparently kept the fluid within the cavity for quite a considerable period of time—so much so that even on washing it out the next day you were able to detect distinctly some remaining odor of the chlorin. This plan was followed by the same reaction, but the convalescence in these cases was cut down apparently from two to four or five days. After the instillation of the first oil and the washing of the second day, we instill the oil for the second time. Then, if the symptoms were not too violent, we refrain from any further intrasinus medication. We did not try to wash the sinus out, but allowed the oil to stay in and gave the sinus a period of rest of about four days. In these cases the convalescence was shorter, the pain was less, and the patients come through in a most satisfactory manner. We used the dichloramin oil on tampons in cases of acute suppurative otitis requiring tympanotomy, and found that the first reaction was, as Dr. Mayer suggests, quite marked. The drum would be reddened, the canal would be reddened, but with a period of twenty-four hours of rest, the discharge would change in character from the serosanguineous discharge to one made not of blood but of an excessive secretion of what apparently was normal mucus. In other words, the secretion was white and clear. In the acute suppurative cases, some of them we felt were aggravated by the use of the dichloramin oil tampons, and we discontinued their use, not being able to accomplish the convalescence of the individual in any less time than we had by other means. We used the dichloramin oil in the acute tracheal cases, cocainizing the trachea rather thoroughly and introducing into it, by means of a tracheal cannula or syringe, thirty minims to a dram of the dichloramin oil solution. This was followed in one or two instances by considerable spasms of short duration, but by very rapid amelioration of the symptoms. In other words, that peculiar dusky red, that intense redness of the mucous membrane, could be seen to be much less upon the next examination. The cough was less, the distress was less, and these cases of what we diagnosed as acute tracheitis cleared up apparently very much more rapidly by the use of the dichloramin oil than they did by other means that we have been using before, but as far as the use in the sinus is concerned, we stand not able to feel that we had been giving something which shortened the pediod of convalescence. In the ear cases, some of them were made worse, apparently worse, by the application and we discontinued its use. In the tracheal cases we saw real, decided benefit.

DR. J. PAYSON CLARK, Boston: I learned that it was important to avoid the use of any metal in the cannula or syringe in its application. I should like to report one case of chronic pansinuitis in which all the sinuses had free discharge from them. In this case I used this solution. I washed the antra out, and the left sphenoid was involved. I washed it out with normal salt solution and boric acid, and irrigated the sinuses—the right and left frontal, the left sphenoid and right antrum—with a Dakin watery solution. The patient went home and had a headache and so much malaise that she went to bed. She absolutely refused to have me continue this treatment, although she was better the next morning.

CLOSING DISCUSSION.

DR. D. BRYSON DELAVAN, New York: Formerly when eucalyptol was employed, that solution was found to be irritating. For that reason Drs. Dakin and Dunham devised the "chlorcosane." Almost anyone with a little experience in chemistry can prepare it, but the Abbott Company furnish it under the formula of Dr. Dakin.

Regarding the important subject of disinfection of carriers, I know nothing that has come out on this subject better than the candidate's thesis of Dr. Friedberg in the last volume of our Transactions. Not only may the crypt of the tonsil contain the offensive germ, but it may penetrate into the tissues of the wall of the crypt to such a considerable depth that even when the disinfectant is brought into contact with the wall of the crypt it does not reach the buried microörganism. The disinfection of the sinuses, too, is a difficult matter. Friedberg believes that when infection has persisted for three or four weeks in spite of treatment, then operative measures are distinctly indicated. There may be some cases in which operation, however, does not seem expedient with them. If we can find a reliable disinfectant we are in a much better position than we should be without it.

American Medical Biographies.

PRICE, JOSEPH (1853-1911).*

JOSEPH PRICE, one of the foremost figures in the development of American Gynecology in the eighties and nineties of the nineteenth century, found gynecology and abdominal surgery twin babes in swaddling clothes and left them, after a life of extraordinary activity, full-grown specialties. He made common and safe the radical operation for the treatment of pelvic suppurations, and taught men in this country how to operate with clamp, *serre noeud*, pins, and external treatment of the stump, and so made hysterectomy for fibroid tumors a safe operation, instead of a most dangerous one. Price's personality reached the hearts, while his writings and clinical teachings in some degree moulded the activities of every surgeon in this country and in Canada. To few men has it been given so to impress their personality and their sturdy convictions on their fellows.

Joseph Price was born in Rockingham County, Virginia, January 1, 1853. He received his early schooling at Fort Edward, N. Y., and attended Union College from 1871 to 1872, but left college to join the engineering corps of the New York Central Railroad.

He took his medical degree at the University of Pennsylvania in the class of 1877, and then served as surgeon on a transatlantic passenger steamer between Philadelphia, Antwerp and Liverpool, making three voyages in all.

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* From the forthcoming "American Medical Biography" by Dr. Howard A. Kelly and Dr. Walter L. Burrage. Any important additions or corrections will be welcomed by the authors.

He began his life's work at the old Philadelphia Dispensary, where he found a hearty coadjutor in one of its directors, Dr. Thomas Wistar. The class Price was raised up to examine and treat and become intimate with in their wretched dwellings, were the off-scourings of a corrupt, boss-ridden, badly governed city, and it is due to his fidelity to these usually neglected opportunities in a most depressing field that he owed his subsequent rapid advancement to the position of one of the foremost surgeons of America. If the slum poor of the city had been queens, instead of queans, they could not have received better and more faithful care at his hands. Often did he, at his own expense, when he was struggling for recognition and for a livelihood, send some sad, worn-out creature to the country for several weeks to convalesce from a severe operation; his warm, Virginia heart was ever peculiarly tender towards the colored women under his care.

"Joe Price," as every one called him, had a racy humor and often found relief from care and complete relaxation in relating to chosen spirits following his work, the comical situations and misunderstandings continually arising in the course of his visits to the city's poor. Let it be noted that his jests about the poor and about the quaint old mammies he met were ever tinctured with a chivalrous, tender sympathy; it was only when discussing his rivals that his humor became grim and the bolt often carried a festering barb.

Price was a devoted admirer of Marion Sims, whose "Uterine Surgery" he knew by heart; he was also a follower and close friend of Sims' peer, Thomas Addis Emmet, and it was for many years his special delight to make up parties of interested Philadelphian and visiting surgeons, to run over to New York to meet Emmet, by special appointment, and see him do a vesico-vaginal fistula, or a perineal, or a cervical operation. The value of these trips was enhanced by the anticipatory graphic and lively picture of what we were to note particularly in the operations; in his zeal Price would grasp his interlocutor's coat or a bit of handy rag, and proceed to demonstrate with a needle and thread, or perhaps he would squeeze and adjust his thumb and fingers so as to demonstrate the principles of some plastic operation under discussion. His admiration for Lawson Tait, whose book, "Diseases of the Ovaries," he knew from cover to cover, drew him to Europe about the year 1887 and brought him into vital contact with England's pioneer surgical genius. Later he made a second visit to Birmingham and the two surgeons corresponded until Tait's death. Price's friends often dubbed him the Lawson Tait of America; as a brilliant, successful surgeon, in a large measure the inaugurator of a new era in this country. The comparison is justified, but on the other hand, although Price had the grave faults of strong bias and impulsive likes and dislikes, he was in every way immeasurably Tait's superior as a man. Joe Price's chief fault was an overmastering jealousy of the nearby successful competitors, and inasmuch as these, too, were but frail and erring mortals, his strictures were naturally often justified; he never knowingly or deliberately falsified.

His surgical technic was of the simplest—with a board for a table top and a little fistful of instruments, he brilliantly executed the most difficult abdominal operations. The secret of his success lay in his fixed purpose in life, his active restless mind, his piercing vision and his long, deft, trained fingers, which were at once the envy and the despair of other surgeons Under Tait's influence, and encouraged by his own phenomenal success in his abdominal surgery, he rejected and ridiculed antiseptics and the germ theory, but he preached "asepsis" as some sort of a different doctrine, and thus practically attained his unparalleled results. Joseph Price easily led abdominal surgery on women in this country for neary two decades He naturally fell heir to the abdominal work of his professor in surgery, D. Hayes Agnew. who was too old to master the new fields opened up; his obstetrical skill was such that R. A. F. Penrose, his professor in obstetrics, constantly relied upon his skill in difficult cases.

Price never held any collegiate teaching position, and yet he taught more men how to do abdominal and pelvic operations, and had more grateful followers than any other man in America.

His kindness to the poor, and a supreme indifference to the bondage of office hours (the despair of his practical brother Mordecai) kept him from accumulating a substantial bank account; the emoluments of a big practice meant but little to him.

He had been engaged for several years to

"Lou" Troth, when Professor William Goodell gave up the Preston Retreat (a large endowed obstetric home), and Price's name naturally at once came up for consideration. But the holder of the position must be married! The opportunities offered in the Retreat for obstetric experience were unsurpassed, the salary was large, and with it went a big, comfortable house and grounds, the concession of office hours and an outside practice, provided the institution was duly cared for. Price's candidacy was settled in the happiest manner by immediate marriage; he was elected and filled the post with zeal and success from 1887 to 1894. The issue of the marriage was three daughters and four sons, none of whom studied medicine.

With C. B. Penrose he was the founder of the Philadelphia Gynecean Hospital (incorporated January, 1888), in which he was succeeded by Penrose and J. M. Baldy. Later he abandoned the Gynecean and opened a large private hospital with Dr. J. W. Kennedy.

He was president of the American Association of Obstetricians and Gynecologists in 1895, and one of the staunch supporters of and contributors to the proceedings of this honorable body of specialists.

Price's great subjects for operation or for a paper before a society, or for a debate, were "Pus in the Pelvis," "Extra-uterine Pregnancy," "Early Ovariotomy," and "Fibroid Tumors"; the vermiform appendix came in, too, for a large share of his attention. When he was known to be in attendance at a meeting, men flocked in and filled the room and crowded the aisles to enjoy his vigorous, spicy discussions; at first somewhat interrupted and hesitant in his speech, he soon warmed up as he felt the sympathy of his audience, until, like Stonewall Jackson dashing at the head of his troops, he carried friends and foes alike with him, as he graphically depicted the lessons drawn from his large experience, and caustically flayed his opponents.

His aggressive militancy for what he held to be the best interests of abdominal surgery is well illustrated by the following story, related to me by Dr. Charles H. Mayo, an eye-witness While Price and his associates in Philadelphia were zealously saving lives by their briliant operations, a competitor was vaunting his simpler, safer cures of the same conditions by the Apostoli electric treatment. Price soon "camped on this trail," as we would express it, and closely followed his work over a series of months, or it may have been for several years. The electro-therapeutist finally announced a paper on his methods before the College of Physicians of Philadelphia. Price significantly asked Dr. Mayo, then visiting him, to be present, as the meeting "was likely to be interesting." Before the hour a dray drove up to the hall and a great number of jars containing big and little tumors and specimens, were unloaded and deposited on a long table in front of the speaker's desk. Then followed Price, who took a little pad out of his pocket and busied himself writing slips and attaching them to the jars. The electro-therapeutist read his paper and cited the numerous patients cured by his conservative methods. Whenever the initials were given Price put additional notes on the slips on the jars. The denouement came when the subject was thrown open for discussion. Price arose, one by one named the cases cured and then exhibited the morbid specimens he had afterwards removed from the patients; a big fibroid cut open to show the streaks of the intense cauterization, and the fact that the growth was uninfluenced; in another case he demonstrated that the needles had penetrated the uterine wall at a point remote from the growth; another patient had acquired "a vicious intestinal adhesion," jeopardizing the operation. The tubes of a "cured" pelvic inflammatory mass were picked up and incised and the pus flowed out. The effect was so crushing that the adversary had the pity of the hearers, but therapeutics were annihilated and electro-therapy received its death blow.

Bitter and unrelenting as a foe, Price was generous to the extreme to friends. He had not the habit of mind for the writing of a scientific or a technical paper, but he saw with prophetic vision the next great steps to be taken in surgery; he grasped them himself and then turned round to pull the rest of the world up to his standpoint, and before he quitted the scene, everyone had in fact gone his way

One of the most difficult, nay the impossible, tasks of a biographer, is to grasp and depict such a personality and to measure the influence of a man like Joseph Price, and yet, as great pioneers, such men as he and his brother Mordecai often accomplish more for humanity than many who have poured forth much wisdom from the laboratory. Alas, the aroma of such a life is evanescent and the pen is inadequate to draw the picture. Those who knew him well chuckle or grow pensive and sorrowful as they recall the talks and the walks and the tours and the operations in which they have been associated with him, and one and all are apt to end up with, "Dear old Joe, I wish he were here now"; those who came on the scene later can never know him.

Price died of an infection (to which he was ever liable), a universal retro-peritoneal involvement of all the glands in the abdomen, so that, in spite of his hurry call to his follower, J. W. Kennedy, to operate, he passed out of the field of his great labors, June 6, 1911. He received the honorary degree of LL.D. from Union College but a month before his death.

There is a good portrait in his biography by Dr. Kennedy in the *American Journal of Obstetrics* for January, 1912.

HOWARD A. KELLY, M.D.

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Book Reviews.

Cancer and its Treatment. By DUNCAN BULKLEY, A.M., M.D., Volume ii. New York: Paul B. Hoeber. 1917.

This volume deals primarily with the basic causes of cancer. The author believes that the cancer problem will not be solved by increasing surgical activity, but through a more careful investigation of its medical aspects; more laboratory study is necessary in order to determine more definitely the metabolic and blood conditions which lead up to cancer. The fundamental principles on which dietary and medicinal treatment and prophylaxis are to be based, are more fully developed, and more data are furnished in this book than in volume one. This work includes lectures on the following topics: cancer as a medical or surgical disease; the influence of sex, age, occupation, race, climate, and food on cancer; the mortality from cancer and an analysis of surgical statistics; inoperable and recurrent cancer, metastases, the blood in cancer; dietetic and medical treatment of cancer; prophylaxis. The author believes that results are given. The author believes that erroneous nutrition is in a large measure responsible for the increase in the morbidity and mortality in cancer, in spite of intelligent surgical treatment; that cancer is a systemic disease of which the tumor is but a local expression; and that satisfactory results can be obtained by dietary and medical means, by a vegetarian diet, perfect mastication, exclusion of alcohol, and by leading a very simple and healthy life. The results of the author's experience are satisfactory, and, inasmuch as the death rate due to cancer has increased 27.7% between 1900 and 1915 under surgical treatment, this incentive to further study and development of medical treatment is most valuable and timely.

Physical Remedies for Disabled Soldiers. By R. FORTESCUE FOX, M.D. New York: William Wood and Co. 1917.

A valuable contribution to the problem of restoring the wounded soldier is offered by this book, "Physical Remedies for Disabled Soldiers." It is a practical survey of the physical methods which may be utilized in the treatment of wounded and invalid soldiers. The book emphasizes the efficiency of physical agencies—fresh air, the sun, heat, cold, wind and water—in curing local injuries and infective or nervous disorders. The work is divided into three parts. The first part deals with hydrological remedies and the indications for their use; remedial baths, and indications in surgical cases, in specific fevers, in nervous, cardiovascular and digestive disorders, and in rheumatic affections, are given. Part two discusses mechanical and electrical remedies. Part three deals with the problem of provision for physical remedies, and the opportunities provided by hospitals and physical clinics. The importance of work as a remedial agent is discussed. The results already achieved at the British spas, and the further possibilities of British marine resorts and climate are mentioned.

Modern Dietetics. By LULU GRAVES. St. Louis: Modern Hospital Publishing Co. 1917.

"Modern Dietetics" is an example of the spirit of progress which is being manifested in the study of the physiological and pathological aspects of nutrition. It offers to hospitals the valuable suggestions of a trained dietitian whose services are indispensable to the interests of medicine. The book deals with the problem of managing the institution commissary, proper methods of buying and storing, scientific preparation and methodical distribution. The food value of various products—milk, butter, vegetables, cereals, breakfast foods, fruits, coffee, poultry, eggs, meats, fish and oysters,—and methods of preparation are given. Special diets are furnished for disease and for various classes of people. Training school work, from both the theoretical and the practical standpoints, is discussed. This volume includes, also, the Atwater tables, prepared by the United States Department of Agriculture, and some selected recipes for hospital use. This book is of value to physicians, medical students, hospital administrators, dietitians and nurses.

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DEDICATION OF ELKS' HOSPITAL.

THE first great hospital built in the United States for the reconstruction of disfigured American soldiers and sailors was formally dedicated on November 16, on Parker Hill, Boston. Just at a time when the nation is beginning to think of peace and the return of her fighting men to civilian life, the dedication of an institution of this sort is peculiarly fitting. Several injured soldiers and sailors now distributed in the hospitals of Greater Boston will be transferred to the new building within a few weeks, and the work of making the men physically fit will be started under direction of physicians and nurses especially trained. Those members of the fighting forces who are disabled and unable to reënter commercial and industrial life will be reconstructed so that they may be educated to use their remaining members to advantage.

The Elks' reconstruction hospital was erected at the cost of about $300,000, and is the first of several which the Benevolent Protective Order of Elks intends to build from a fund of $1,000,000 raised by the lodges throughout the country. It is situated on the highest point of Parker Hill. The buildings are connected by tunnels with the Robert B. Brigham Hospital, which will supply heat, light, and kitchen and laundry materials. There are seven wards, each having thirty-four beds. An eighth ward is subdivided into seven private rooms for commissioned officers. The administration offices and halls are in the center building. There is a shop building, where soldiers and sailors will receive instruction in numerous trades while the reconstruction of their physical defects is being made. The methods applied to restoring the crippled men to active usefulness which will be used at the hospital are taken from the French, who have been unusually successful in rebuilding the crippled.

Members of Elk lodges from all parts of the country visited Boston for the dedication ceremonies. John K. Tener, former Governor of Pennsylvania, and chairman of the Elks' War Relief Commission, presided at the exercises. The Government was represented by Major-General William A. Crozier. Grand Exalted Ruler Campbell is reported to have said in part:

"The building of this hospital is one of our contributions to meet our new duties and circumstances. Although a result of the war, it is not a preparation for war, but for peace.

"Some three million men will soon cease being soldiers and become peaceful citizens; many of them have been wounded or weakened by sickness and will not be able to resume the vocations and trades of the pre-war period. Toward these particularly we have a duty to perform. The duty is fourfold, *viz.:* Their physical construction, vocational training in order that they may become useful citizens, proper attitude of the public toward them, and proper attitude of the soldiers toward the public.

"A part of that work will be done here. Within these walls there will be, in many cases, either in part or in whole, the physical reconstruction of the body. Where disability prevents the return of the soldier to his former vocation or occupation, he will be given a new one in order that he may be a useful citizen of the Republic."

"SHELL SHOCK": A NEW POINT OF VIEW.

WE have recently received through the courtesy of Dr. Henry R. Stedman, a copy of the *Weekly Bulletin* No. 20, issued from the office of the Chief Surgeon of the American Expeditionary Forces in France, August 26, 1918, and distributed by the War Work Committee of the National Committee for Mental Hygiene in New York City.

This bulletin aims to present a new point of view with reference to "shell shock," pointing out that "shell shock" is not a medical term, that preventable disease is not all of bacteriological origin, and that much of the sick wastage in armies is due to infected thoughts and careless words.

"In spite of the fact that the circular regarding sick and wounded reports states clearly that the term 'shell shock' will not be accepted as a diagnosis of disability or death, it is still being used by medical officers in many tactical divisions and base hospitals. As everyone now knows, the prevalence of the war neuroses in an Army is in our own hands nearly as much as the control of infectious diseases. There are measures which tend to suggest functional nervous diseases and there are others which tend to prevent them. It is the duty of medical officers to try to prevent mental and nervous diseases, as well as communicable ones of infectious origin, and there is no excuse for suggesting permanent or semi-permanent nervous invalidism to a man suffering from concussion or exhaustion by using the term 'shell shock' on his diagnosis tag or field medical card. If the medical officer thinks that a man has been 'concussed' or is physically exhausted he should say so, and if he thinks that the soldier is suffering more from nervousness than from concussion or exhaustion he should say so by using the terms provided in the nomenclature of diseases or the symbol, 'N. Y. D.,' followed by 'nervous' in parentheses. Many a good soldier is being lost to the front lines through carelessness in this matter, for few men can withstand the suggestion of disease when that suggestion is made by those whom they rightly regard as authorities in medical matters.

"The control of war neuroses is one of the great new medical problems of this war. Those directly responsible for dealing with the problem are working hard to minimize those disorders in the A. E. F., but they need the help of every company and regimental medical officer and every man on the staff of a base hospital. Do not use the term 'shell shock' yourself, either in reports or in conversation, and do not permit nurses and hospital corps men under your direction to use it. It is not a medical term, but a piece of military slang which applies to a large group of conditions; a name which is descriptive of only a small proportion of all cases. It is not permitted in the British or French armies nor in the armies of our enemies. To discontinue using it shows a desire to preserve man-power, to be accurate and clear in medical nomenclature and to follow regulations framed after thoughtful consideration; to continue using it shows clinical slovenliness, disregard for regulations and indifference to the preventable wastage of man-power. This is a little thing, but so was the nail for lack of which the horseshoe, the horse, the rider and a kingdom were lost. During the recent severe fighting around Chateau-Thierry a large number of soldiers were sent into the S.O.S. with the diagnosis of 'shell shock.' In cases where division psychiatrists were allowed to work at sorting stations, more than half of the cases who came back from the lines from this diagnosis were returned to their organizations. Of those who had to be sent farther back, about half were successfully treated in a few days in field hospitals. In most cases, however, division psychiatrists were required to assist in dressing surgical cases, while hundreds of able-bodied men of their divisions were being sent through field hospitals to hospitals in the S.O.S. with a diagnosis of 'shell shock.' The psychiatrists could have been better used saving men from the fear of nervous disease by immediate estimate of their condition and prompt return to duty."

The idea contained in this communication is quite new, at all events, in this country. It gives a light on "shell shock" and allied nervous phenomena which is original, interesting, true and important. It was Dr. Oliver Wendell Holmes who originally pointed out the suggestive influence of what he termed "polarized" words. The same phenomenon may be observed in the influence exerted by certain medical or pseudo-medical terms upon suggestible or psychoneurotic patients.

DISTINGUISHED SERVICE CROSS AWARDED BOSTON PHYSICIAN.

We have recently received information that the "Distinguished Service Cross for extraordinary heroism in France has been posthumously awarded to Lieutenant George P. Howe, M.C.U.S. Army, Boston, who was killed in action, September 28, 1917." This is a worthy tribute to the first Boston physician who was killed in the war service.

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MEDICAL NOTES.

Peter Bent Brigham Hospital.—The Fourth Annual Report of the Peter Bent Brigham Hospital, for the year 1917, has just been issued by the University Press. All the departments are affected by the war conditions. Dearth of candidates and consequent difficulty in filling vacancies have made it seem wise to elect women as house officers and members of the staff, but in spite of all the difficulties encountered, the hospital has been able to keep up its efficiency and high standards.

It is of interest to note that the Social Service Section has done a great deal for the outdoor patients in securing permanent or temporary homes for convalescents, and in adjusting misunderstandings between schools, homes, and the hospitals.

At the request of the Red Cross Nursing Service, a 72-hour course for nurses' aids, open to those who have passed a satisfactory examination in certain classes given by the Red Cross, has been inaugurated. Miss Hall, superintendent of nurses, has taken charge of a unit of nurses going to France with University Base Hospital No. 5. The Pathological Department lays emphasis upon the continuation of research as a fundamental requisite toward progress. This department has felt very keenly the lack of sufficient aid in the maintenance of efficient routine. This lack of experienced and trained assistance is especially felt in the Surgical Department, which requires experienced men for operative therapeusis and after-care of cases. However, the number of surgical admissions in 1917 was 1,942 as compared with 1,787 in 1916. An account of the fatalities is incorporated in the report. The Physician-in-Chief is particularly desirous of installing a hydro, thermo, mechano-therapeutic department with proper equipment to assist in the reëducation movement for the wounded.

The classes in cardiac, diabetic and renal diseases were continued and instruction and care given to a number of patients in this way. Owing to the gift of Mr. Charles F. Choate, the knowledge of bronchial asthma was greatly increased and cures were effected in a number of cases.

WAR NOTES.

Preparedness League of American Dentists.—More than 650,000 free dental operations were performed by members of the Preparedness League of American Dentists prior to November 1. All this work was done on men drafted for military service, but who were, in many instances, dentally unfit for military duty. Members of the League are located in every State in the Union and in many instances have made individually several hundred men dentally fit for service.

War Relief Funds.—On November 19 the totals of the principal New England War Relief Funds reached the following amounts:

Belgian Fund	$718,296.93
French Wounded Fund	438,256.83
Armenian-Syrian Fund	315,292.97
Italian Fund	226,142.22
LaFayette Fund	44,177.41
British Fund	19,796.83

Deaths from Influenza in the Service.—The War Risk Insurance Bureau has estimated that the number of deaths caused by influenza among soldiers and sailors has amounted to 18,000 in this country alone. At the present time, however, the epidemic appears to be checked. Figures for the week ending November 8 show 6,887 cases as compared with 18,175 the previous week. The progress of the epidemic is being checked also in the West, the last section to be affected. Marked improvement generally was shown in the Surgeon General's weekly report in regard to the pneumonia situation.

A mild epidemic of scarlet fever was reported at Camp Hancock, Georgia, with fifty-one cases during the week.

724 Sick and Wounded American Soldiers Home.—The total number of sick and wounded men landed in the United States from the American Expeditionary Forces for the week ending November 8 was 724.

SPRINGFIELD ACADEMY OF MEDICINE.—The November meeting of the Springfield Academy of Medicine was held in Springfield on the evening of November 12. A new treasurer was elected to take the place of Dr. A. G. Rice, who has entered the Army. An address, "The Present Epidemic of Influenza Among Children," was delivered by Dr. Fritz B. Talbot of Boston. DR. L. D. CHAPIN, *Secretary*.

DR. DONLAN IS REINSTATED.—Dr. Charles E. Donlan, superintendent of the Boston Almshouse and Hospital on Long Island, who was removed last summer by order of the Boston Infirmary Trustees, has been restored to duty. Judge Murley, of the East Boston District Court, found that the order for his removal was made without proper cause.

Dr. Donlan assumed charge of the Long Island Hospital and Almshouse May 2, 1908, succeeding James F. English.

He received his degree in medicine from Harvard in 1898. He has made two trips to Europe, in 1899 and 1905, for the purpose of study in advanced medicine and sociology.

WEEK'S DEATH RATE IN BOSTON.—During the week ending November 16, 1918, the number of deaths reported was 230 against 223 last year, with a rate of 15.29 against 15.06 last year. There were 25 deaths under one year of age against 32 last year.

The number of cases of principal reportable diseases were: Diphtheria, 38; scarlet fever, 22; measles, 4; whooping cough, 8; tuberculosis, 37.

Included in the above, were the following cases of non-residents: Diphtheria, 5; scarlet fever, 2; tuberculosis, 2.

Total deaths from these diseases were: Diphtheria, 3; tuberculosis, 21.

Included in the above, were the following non-residents: Diphtheria, 1; tuberculosis, 3.

Influenza cases, 71; influenza deaths, 27, of which four were non-residents.

INFLUENZA AND PNEUMONIA IN BOSTON.

Cases Reported and Deaths by Date of Death from Sept. 7, 1918, to Sat. Noon, Nov. 9, 1918.

		Cases Reported		Deaths Reported		
Date		Lobar Pneumonia	Influenza	Pneumonia All forms	Influenza	Total Deaths
Sept.	7			3		2
	8			3	2	5
	9	3		4	4	8
	10	3		7	2	9
	11	8		5	3	8
	12	2		7	8	15
	13	3		12	4	16
	14	7		20	11	31
	15			9	15	24
	16	13		14	29	43
	17	20		10	28	38
	18	22		7	44	51
	19	22		18	53	71
	20	21		21	54	75
	21	23		22	54	76
	22			19	77	96
	23	48		30	97	127
	24	49		31	93	124
	25	35		29	121	150
	26	51		33	129	162
	27	55		27	135	162
	28	40		31	140	171
	29			47	131	178
	30	63		47	120	167
Oct.	1	43		30	162	192
	2	30		22	188	210
	3	37		36	152	188
	4	22	*25	29	142	171
	5	41	90	25	143	168
	6	23	104	23	132	155
	7	8	77	23	122	145
	8	31	179	19	100	119
	9	16	295	24	90	114
	10	14	205	23	89	112
	11	19	280	20	92	112
	12	11	320	17	87	104
	13			18	77	95
	14	6	312	22	56	78
	15	27	387	17	40	57
	16	8	249	10	41	51
	17	33	99	7	47	54
	18	13	67	13	36	49
	19	18	74	8	26	34
	20			13	23	36
	21	14	85	5	31	36
	22	12	105	5	13	18
	23	10	21	6	22	28
	24	3	32	6	21	27
	25	2	35	3	12	15
	26	2	26	6	9	15
	27			4	16	20
	28	6	61	9	17	26
	29	1	15	9	8	17
	30	23	43	1	17	18
	31	12	25	4	3	7
Nov.	1	3	42	5	7	12
	2	6	14	1	8	9
	3			3	6	9
	4	1	20	3	6	9
	5	1	15	4	9	13
	6	3	2	1	10	11
	7	0	15	3	4	7
	8	5	12	1	3	4
	9	5	8	0	0	0
Total		997	3390	988	3421	4354

* Influenza reportable since Oct. 4, 1918.

DISTRICT NURSES' WORK IN OCTOBER.—Nurses of the Instructive District Nursing Association of Boston have had 5,439 new patients in October, and 39,690 visits were made. In October, 1917, 1,441 new patients were taken on and 15,713 visits were made. The increase is due to the influenza epidemic.

$100,000 BEQUEATHED TO LAWRENCE HOSPITAL.—By the will of Morton F. Plant, $100,000 has been bequeathed to Lawrence Hospital of New London.

EPIDEMIC RETURNS TO LAWRENCE, MASSACHUSETTS.—Influenza cases are being reported at the local Board of Health in Lawrence in such numbers that it is feared that it may be necessary to put a ban on public gatherings again. During a period of 24 hours, the number of cases discovered by physicians and nurses throughout the city numbered fifty, which is as high as certain days during the epidemic of several weeks ago.

RUTLAND SANATORIUM IN NEED OF MONEY.—Dr. Livingston Farrand, director of the American commission for the prevention of tuberculosis in France, has made an appeal to the people of the United States urging them to use every measure to combat tuberculosis. He has asked them to work with as much zeal for eliminating this disease as for the destruction of Prussianism.

The Crane sanatorium, which is being erected in Rutland, Massachusetts, is immediately needed for treatment of patients of moderate means who do not desire to enter state or municipal institutions. The federal bureau of war risk insurance, which finds difficulty in obtaining adequate accommodations for discharged soldiers and sailors, has stated that it "can make the most ample use of it."

Further subscriptions for this sanatorium—at least $10,000 a month for the next four months—are necessary to hasten its construction. They may be sent to Leonard W. Cronkhite, treasurer, care of the Merchants National Bank, Boston.

FRAMINGHAM COMMUNITY HEALTH AND TUBERCULOSIS DEMONSTRATION.—A thorough investigation of sanitary conditions has been made in the development of the Framingham Community Health and Tuberculosis Demonstration program. Monograph No. 3 deals with the statistical phase of the sanitary survey and covers a period of ten years. The study presents the following main conclusions:

There is a close correspondence between the local and national mortality statistics. An analysis of mortality for five years indicated that the tuberculosis death rate was probably twenty-two per cent. greater than the actually recorded rate. The community is growing rapidly, particularly in the lower age groups and among the foreign born. There has been no marked improvement in the mortality rate during the last decade. The leading causes of death are organic heart disease, Bright's disease, cerebral hemorrhage, pneumonia, cancer, and tuberculosis, in the order named. Tuberculosis and infant mortality present the best opportunities for attack upon the mortality rates. The less prosperous districts have markedly higher general death rates, a fact which indicates the importance of the economic factor and the need for special effort in disease preventive work in the poorer districts.

NURSES GRADUATED AT PETER BENT BRIGHAM HOSPITAL.—On Thursday evening, November twenty-one, the graduating exercises of the School for Nursing of the Peter Bent Brigham Hospital were held. A reception followed the exercises.

Obituary.

HARRISON BRIGGS WEBSTER, M.D.

MAJOR HARRISON BRIGGS WEBSTER, a regimental surgeon in the 47th Infantry, was killed in action in France on October 7. Major Webster is the second Boston physician to lose his life in war service. He was the son of Andrew G. and Florence Briggs Webster of 191 Commonwealth avenue. He prepared for college at Noble & Greenough's School. He was graduated from Harvard with the class of '05 and then attended Harvard Medical School, from which he was graduated in 1909. He went to Plattsburg, and was then sent to a medical camp at Fort Benjamin Harrison at Indianapolis, Ind. He went overseas last May.

After his graduation from medical school Major Webster spent two or three years with

Dr. Grenfel in his Labrador mission, and then went to Castine, Me., where he practised for a time. He is survived by his wife, who was Miss Margaret Gleason of Northampton, and three children; also by one brother, Captain David Webster, who is in the aviation service at Hampton, Va.

◆

Correspondence.

MOBILIZING THE MIND.

Warwick, Mass., November 11, 1918.

Mr. Editor:—

Mistakes will happen in the best regulated families. The war emergency organizations are no exception to the rule. Fully one quarter of the physicians are in active service. As the younger and most vigorous of the profession are so enlisted, the potential energy of the remainder left to serve in their home fields is very far from 75%. An extraordinary epidemic breaks out; the home guards are inadequate to meet the demands in the congested towns. Mobilization of physicians from the outside is necessary. The State health boards through the U. S. Public Health service makes use of an organization but a few months old to draft temporary medical help. Some far seeing leaders of the National Council of Defense, Medical Section, had started the Volunteer Medical Service Corps and though this had seemed to many as an unnecessary endeavor, the U. S. Public Health service was very glad to be able to turn to it for men to serve in the influenza epidemic.

Several lessons may be taken from the following communications in the columns of a local paper which show how the lime light is thrown upon the possible or actual indiscretions of a doctor in such a way as to very much overshadow in the minds of the public his actual and intentional efforts to serve and minister in a strange field.

"Grieved at Reference to Doctor."

"*Editor of the* ——— ——— ———:—

"In your issue of first instant I note the following item:

"'Depressing and regrettable as were the consequences of the influenza epidemic in ———, the period of four weeks was not without its humorous side. Some strange experiences took place which, though irritable and deplorable at the time, are now the cause for considerable merriment among the nurses and townspeople. Much of it resulted from the actions of one of the emergency doctors whose coming was as sudden as his departure was welcome. It cannot be said that his work was very creditable to the medical profession, and the local authorities promptly dispensed with his services.'

"Whatever may have been the 'consequences' of the influenza epidemic, the maligned doctor did not add to its fatalities. The accusations contained in the item are too serious and reflect too much upon the ingratitude of our town to be 'humorous.' It is indeed regrettable that there is even one individual in the town of ——— so base as to publicly slur or slander, or cast the slightest reflection upon the work, or person, of any of those who gave help and assistance in our time of need,—no matter how exalted or humble the service rendered.

"The doctor referred to came in response to a telegram sent to the Emergency Health Board, by the writer, upon request of Dr. ——— for an assistant. While the 'emergency' doctor's voice may not have been so soft, or his language and manner so gentle and refined as to make his ways and treatment of patients the ways and treatment which some of our omniscient cast-in-the-mould nurses may have desired, nevertheless, in the language of one of our old-time citizens, he 'never lost a case.'

"Most of the families visited by the so-called discredited member of the medical profession were those furnished him by Dr. ———, and I am authorized by the latter to say that he is in entire accord with the medicines prescribed, and the treatment rendered by the man, who gave up his practice in N. Y. City, offered his services to the U. S. Government, and was sent to us to aid, help and assist in the time of our distress.

"I do not believe the ingratitude apparent and intended in the article to which I am making reply, represents the majority sentiment of the citizens of this town. Permit me to add that no patient, no member of any patient's family, no nurse or no doctor, although requested by me to do so, did or would make any complaint, in writing, against this emergency doctor, who was so much despised and so much criticized by some of his co-workers.

"In closing, I would esteem it a great favor to be privately informed (if my informant prefers not to make the matter public) what local authorities, if any, were instrumental in dispensing with the alleged objectionable doctor's services."

"Editor's note: It is to be regretted that the article in our last issue of November 1st, referred to above, should have occasioned such an outburst. So far as the doctor in question is concerned, little comment need be made. All who came in contact with him are judge of his fitness. Those prominent in the visiting nurse association were so disgusted with his attitude that complaint was entered with the State authorities. Prescribing a chew of gum for a patient critically ill, refusing to take asepsis precautions in confinement cases, using language that was hardly proper and showing a questionable attitude toward lady nurses are actions which we believe discreditable to the profession. Perhaps we are wrong! A good majority in town have been less concerned about who fired him as to who hired him."

The writer has a considerable acquaintance with the town above referred to and among its people. He has no acquaintance with the doctor in question. In writing this there is no desire to defend misconduct. We all realize that well intentioned "jollying" will not be taken in one place as it will be in another. The differences between a metropolitan trained mind and a rural or near rural bred one are most radical. The home of the former is constantly receiving every kind of race, person, character, idea, habit, practice, etc., and giving to the same more or less of recognition and protection. In the small or provincial town, dominating characters become so entrenched that the inhabitants become, perhaps unwittingly, polarized in very acts and habit of thought to speaking or thinking with a deference or salaam to the selfish interests of those few. Greed makes use of jealousy and minor human traits and weaknesses of character to guard its prerogatives. The small town has essential autocracy. Whatever is foreign or novel to its own limited tradition and custom is looked upon very suspiciously. It has a very real method of censorship and the presence of an alien means a possible menace to the established order and is sure to arouse animosities and hatred.

The lumberjack pent up through the winter in the woods can't restrain himself when he gets to "town." Even the visitor from the small town when he gets to the city gives himself a rather generous rein in "seeing the sights" as he feels "no one is any the wiser" back home. Many a professional or business man takes a debauch, justifiable or otherwise, by going into the country to hunt, to fish, for diversion, wholesome or unwholesome. His overwrought or overtaut nerves undergo such a relaxation under the changed environment that ordinary intellectual processes, discriminations, perceptions are swamped by the flood of and the appeals to the sensual side of him. To illustrate this matter of release from tension upon a plane that affects us all. For almost four years and four months, the world body has been under the strain of war. Today official announcement is made that the great enemy has practically surrendered. Men and boys cannot work and think but are giving way to yelling and irrational impulse. From here the constant tooting of whistles can be heard at distances of from 7 to 10 miles taking their part in "blowing off steam." These are rather obvious examples showing the reaction when long continued conditions provoke a state of tenseness physically or temperamentally, and when a real interruption is allowed.

A doctor from one of the most tolerant city atmospheres is assigned to help out in a factory town where a pseudo-puritanism and a topography (rocks and rills) have inbred and crystalized intolerance. He had the scientific training adequate to fight disease and germs of the physical type usual to one of his professional standing. He probably had sufficiently that art of practice and adaptability which at the time he started his professional work, would have easily acclimated him to such a stony mental field, but his years were against him. He was to do what he could in the most comfortable way he could. There was humor to the situation upon his side. For various reasons New York City was able to furnish a conspicuously large number of men for this volunteer medical service, men not so adaptable for the Medical Reserve Corps, but whose motives for a near war experience may have been as laudable as those able to go into the real one. The contrast between the smooth running machinery of a health organization in a large city and the same of a small town is most striking, and when such an epidemic overtakes the latter, its weakness is shown up.

With all the hardships and strangeness, the experience in the army and at the front has its physical and mental phases which are refreshingly recreative. Why then should not these New York men going out so, take a somewhat vacational viewpoint of their experience. Nature keyed up will let down when given a chance. The army has safeguards for checking up men on duty, but here was a situation unforseen where organization was inadequate. Our profession is well organized to make a good showing in fighting physical germs in their most favorite nesting places—the large cities and towns. The mental atmosphere of such places affects no serious injunction against such warfare. However, as one departs farther and farther from congested areas, skepticism regarding the most modern and the approved enters in. Much of the scientific readily accepted in districts near to the most active and progressive centres gets hashed up with the tradition and customs of a place distant or isolated. Now a man coming into such a field for such a short period has little opportunity to analyze such local temperament and environment. The physical air is refreshing and relaxing to his nerves, the mental atmosphere is a puzzle and may seem cold and forbidding and be quite a test to his professional good nature. His affidavits of standing and ability are not proof against what local jealousy may do to undermine his best conduct. He deserves in this situation extra consideration and encouragement. If he is not made to feel welcome and at home, he feels lonely; and any weakness of disposition or habit is likely to be shown up or aroused. Again, the Medical Service Corps is filled with the more adaptable and vigorous of the profession and has a system of props which has been worked out through a long period of time, to hold the men in place, while here was an organization hastily constructed to meet contingent needs and calling for volunteers from the medical men left. Undoubtedly the collective experience of the few hundred men mobilized for this volunteer service could be made a valuable contribution to medical annals.

The army must adapt itself to the latest scientific procedure in medicine as it does to all that is new and progressive in the enginry of warfare. The army surgeon devotes more time to a practical form of health insurance for the efficiency of the soldiers than does the medical man at home for the civilians. Army life means preparation for and adaptation to various localities and environments with all their topographical and climatic differences. A rolling stone gathers no moss and many of the encrustations of an army in peace are lost during the mobilization for war. Though many pacifists may have feared that this war would develop hatred, prejudices and animosities, the ultimate results will undoubtedly show victories for more brotherly feelings between nations and for tolerance in spirit and vision. It is sincerely to be hoped that such a wholesome ferment now working between races and peoples in these large units will percolate down to the smaller ones—that isolated communities and districts, individuals may mobilize to healthier spiritual planes and zones.

Paul W. Goldsbury, M. D.

GRIPPE AND NASAL SINUSITIS.

541 Commonwealth Avenue.
Boston, Massachusetts.

Mr. Editor:—

In a paper entitled "Shall We Never Learn?" Dr. Lewis of New Haven does me the honor of mentioning in his references a paper of mine entitled "Epidemic Nasal Sinusitis: 'Influenza' and 'Grippe' Its Misnomers," *Medical Record*, May 26, 1917. The major part of Dr. Lewis' paper is an appeal to reason, for reason in the handling of so-called grippe epidemics. With this theme I can heartily agree, as I made a similar appeal as early as 1916, in the month of January. There is, however, a minor chord in his paper, which I do not like. I speak of his classifying his references as confirmatory material of something which he had previously written, but which he catalogues as "disjointed and lacking basic formation." Passing over the question of time, as to which one of us is affirmatory, and which confirmatory, I come to his statement that the collected evidence is "disjointed and lacking basic foundation."

If this were an unanimous verdict it would give me pause, but coming from Dr. Lewis, "walking alone," I do not accept it. Parallactic displacement on this, as on every human question, depends on the point of view. Dr. Lewis sees the question of "grippe" from the standpoint of an epidemiologist, I, from that of the rhinologist. Primarily, he deals with communities, I with individuals. Our work is necessarily interdependent. At times we will enter each other's domain. We will often agree. We must never disagree. This demands recognition of the fact that neither of us knows it all. For my part, I am always open to conviction. *Per contra*, I wish to object to a point or two in Dr. Lewis' paper, which are evidently due to his misconstruction of mine. He has no right to draw the inference that my paper suggests that epidemics of "grippe" start from cases of chronic sinusitis alone, because while I am convinced that they may, I know that they actually start as a rule from acute cases.

My second objection in this paper is the writer's allusion to an "innocuous watery head cold." I do not recognize such a condition. I call it what I believe it is. An acute mucous sinusitis dependent for its virulency on the infecting organism.

Dr. Lewis will admit the distinction between a serous and a purulent meningitis. Why be single tracked on the nasal sinuses?

Without adding or subtracting a word, all these distinctions can be found in my article in the *Medical Record* of May 26, 1917. Furthermore, I said at that time, "that as long as the nasal sinuses escaped, the clinical picture of 'grippe' would be wanting."

In this epidemic the nasal sinuses did apparently escape, the clinical picture was lacking in something, and we had to invent the adjective "Spanish." But this escape was only camouflage. The sinuses did not escape. We had a sinusitis, which was not a suppurative one. That is all. Let me use the form of proportion to describe my view of the situation.

Acute mucous sinusitis; Acute suppurative sinusitis; Spanish influenza; influenza.

Or in other words. An acute mucous sinusitis, caused by a high grade bug of exceptional virulence, which did not stop to make pus in the sinuses, but which was carried off by the upper set of deep cervical lymphatics, retro-pharyngeal (witness reddening of pharynx and larynx) to thoracic duct, subclavian, right heart, lung, left heart, to the general circulation. Hence the pneumonia and septicaemia.

Treatment. If this view is accepted the treatment must be altered. Antiseptic douches are objectionable for more reasons than one. From the standpoint of otology they are dangerous. If strong enough, they are destructive. If too weak, useless. They are irrational as they only flush the overflow, and do not attack the factory or source. These patients were profoundly septic. They did not lend themselves to travel in an ambulance. The pneumonia masked the real story—which was sepsis. And the treatment of sepsis indoors or outdoors, is diuresis, diaphoresis, catharsis, support of the heart, and last but not least the cleaning up of the focus, in this case the nasal sinuses This last is a mechanical problem for which we have only two remedies: 1. Cocaine and adrenalin; 2. Surgery.

Yours for reason,
John J. Hurley, M. D., F. A. C. S.
November 16, 1918.

COLLECTION OF SCRAP PLATINUM.

War Industries Board, Washington.
November 13, 1918.

From: Mr. Charles H. Conner, Chief, Platinum Section, and Lieut. Col. F. F. Simpson, M. C., U. S. A., chief of Section of Medical Industry.

To: The Doctors and Dentists of the Country.

Subject: Cancellation of Appeal for the Collection of Scrap Platinum.

1. The Platinum Section and the Section of Medical Industry, War Industries Board, desire to express appreciation of the hearty response made by physicians, dentists and others when the call for scrap platinum was made.

2. As the Governmental demand for platinum in the making of explosives, etc., has been tremendously decreased by the curtailed war program, it is requested that no further scrap platinum be tendered to the Government through the channels indicated in our communication of September 17th, 1918.

Charles H. Conner, Chief,
Platinum Section.
Lieut. Col. F. F. Simpson, M.C., U.S.A.,
Chief of Section of Medical Industry.

AMERICAN RED CROSS: SURVEY OF NURSES.

Boston, Nov. 21, 1918.

Mr. Editor:—

The American Red Cross has been asked by the medical authorities of the Government to make a survey which will include a registration of all women of the country who have had training or experience in nursing. Previous surveys about the nursing profession have been made, but they were not national in scope and the information secured from them is inadequate for the present and future needs of the government.

The purpose of the survey is to determine how many graduate nurses can be released for military service without detriment to the needs of the civilian population. There are many women in the country with some training and experience in nursing who can be used in an emergency, under proper supervision. This survey will reveal how many semi-trained women are available for this purpose.

The Boston Metropolitan Chapter of the Red Cross asks your coöperation in making this survey a success. Much work has already been done, but we need your assistance in locating nurses who are not registered.

Will you, therefore, be good enough to send me, as soon as possible, the names and addresses of the women, known to you, who are trained nurses or who can be depended upon to do intelligent nursing when the need arises? The questionnaire calls for information about graduate nurses, pupil nurses, ungraduated nurses, trained attendants, practical nurses, etc., and filling out the questionnaire is not a pledge of service.

Your interest and coöperation in helping the Red Cross to accomplish successfully its very important task will be deeply appreciated.

Faithfully yours,
(Miss) Guenn Cooke, *Executive Secretary*.
Nursing Survey, Boston Metropolitan Chapter.

SOCIETY NOTICE.

New England Pediatric Society.—The fifty-fourth meeting of the New England Pediatric Society will be held at the Infants' Hospital, 55 Van Dyke, Street, Brookline, on Friday, Dec. 13, 1918, at 4.30 P.M.

I. The Treasurer's Report.
II. The Report of the Council and Nomination of Officers.
III. There will be a presentation of cases and discussion by
Charles Hunter Dunn, M.D., Boston,
William W. Howell, M.D., Boston.
IV. Election of Officers.

Charles Hunter Dunn, M.D., *President*.
Richard M. Smith, M.D., *Secretary*.

RECENT DEATHS.

First Lieutenant William S. Moriss, M. D., of the United States Army, died recently after a short illness of bronchial pneumonia. Dr. Moriss was a graduate of Harvard College and of the Harvard Medical School. At the outbreak of the war, he enlisted in the Army Medical Corps, and had been stationed at Jacksonville, Florida.

Abbott Lathrop Cooley, M.D., a graduate of the University of Michigan in 1897, and a Fellow of the Massachusetts Medical Society, died at his home in Chicopee Falls, Mass., October 28, 1918, of pneumonia.

Arthur Hardy Cutter, M. D., died at his home in Methuen, October 4, 1918, of pneumonia. He was a graduate of Harvard Medical School in 1901 and was chief of the surgical staff of the Lawrence General Hospital. He was 45 years old.